Date Received

FOR BOARD OF HEALTH USE ONLY

Date Inspected

Approved By

Permit # Issued

THE COMMONWEALTH OF MASSACHUSETTS

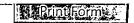
TOWN OR CITY OF	

Food Establishment Permit Application
(Application must be submitted at least 30 days before the planned opening

		o days before the planned opening date)			
1. Establishment Name:					
2. Establishment Address:					
3. Establishment Mailing Ad	dress (if different):				
4. Establishment Telephone l	No:				
5. Applicant Name & Title:					
6. Applicant Address:					
7. Applicant Telephone No:		24 Hove Francisco V			
TIF	7. Applicant Telephone No: 24 Hour Emergency No:				
8. Owner Name & Title (if di	fferent from applicant):				
9. Owner Address (if differen	t from applicant):				
10. Establishment Owned By:	11. If a Corporation	ion or Partnership, give name, title, and home address of			
An Association	officers or partner.	t.			
A Corporation	<u>Name</u>	<u>Title</u> <u>Home Address</u>			
An Individual					
A Partnership					
Other Legal Entity					
12. Person Directly Responsible	e For Daily Operations (Owner, Person	on in Charge, Supervisor, Manager, etc.)			
Name & Title:					
Address:					
Telephone No:					
Emergency Telephone No:	Fax:				
13. District or Regional Superv	isor (if applicable)				
Name & Title:					
Address:					
Telephone No:		Fax:			

Food Establishment Information

14. Water Source:		15. Sewage Disposal:
DEP Public Water Supply No.: (if applied	cable)	
16. Days and Hours of Operation:		17. No. of Food Employees:
18. Name of Person In Charge Certified Required as of 10/1/2001 in accordance with 105 of	in Food Protection Management:	
19. Person Trained in Anti-Choking Pro		No
20. Location (check one) Permanent Structure Mobile	Establishment Type (check all that apply) Retail (Sq. Ft.) Food Service – (Seats)	Caterer Food Delivery Residential Kitchen for Retail Sale
	Food Service – Takeout Food Service – Institution	Residential Kitchen for Bed and Breakfast Home
21. Length Of Permit: (check one) Annual Seasonal/Dates:	(Meals/Day) ner (Describe)	Residential Kitchen for Bed and Breakfast Establishments Frozen Dessert Manufacturer
Temporary/Dates/Time:		
23. Food Operations: Definition (check all that apply):	Non-PHF's – non-potentially hazardous f	emperature controls required) food (no time/temperature controls required) s, salads, muffins which need no further processing)
Sale of Commercially Pre- Packaged Non-PHF's	PHF Cooked To Order	Hot PHF Cooked and Cooled or Hot Held for More Than a Single Meal Service.
Sale of Commercially Pre- Packaged PHF's	Preparation Of PHFs For Hot And Cold Holding For Single Meal Service	PHF and RTE Foods Prepared For Highly Susceptible Population Facility
Delivery of Packaged PHFs	Sale of Raw Animal Foods Intended to be Prepared by Consumer.	Vacuum Packaging/Cook Chill
Reheating of Commercially Processed Foods For Service Within 4 Hours.	Customer Self-Service	Use Of Process Requiring A Variance And/Or HACCP Plan (including bare hand contact alternative, time as a public health control)
Customer Self-Service Of Non- PHF and Non-Perishable Foods Only.	Ice Manufactured and Packaged for Retail Sale	Offers Raw Or Undercooked Food Of Animal Origin.
Preparation Of Non-PHF's	Juice Manufactured and Packaged for Retail Sale	Prepares Food/Single Meals for Catered Events or Institutional Food Service
	Offers RTE PHF in Bulk Quantities	To be completed by the Board of Health
	Retail Sale of Salvage, Out of Date or Reconditioned Food	Total Permit Fee: Payment is due with application
I, the undersigned, attest to the accuracy will comply with 105 CMR 590.000 and 105 CMR 590.000 and the Federal Food	l all other applicable law. I have been instructe	n and I affirm that the food establishment operation ed by the Board of Health on how to obtain copies of
24. Signature of Applicant:		
Pursuant to MGL Ch. 62C, sec. 4 filed all state tax returns and paid	49A, I certify under the penalties of perjury the d state taxes required under law.	nat I, to my best knowledge and belief, have
25. Social Security Number or Federal	ID:	
26. Signature of Individual or Corporate	e Name:	





The Commonwealth of Massachusetts Department of Industrial Accidents Office of Investigations 1 Congress Street, Suite 100 Boston, MA 02114-2017 www.mass.gov/dia

Workers' Compensation Insurance Affidavit: General Businesses

Applicant Information	Please Print Legibly	
Business/Organization Name:		
Address:		
City/State/Zip:P	hone #:	
Are you an employer? Check the appropriate box: 1. I am a employer with employees (full and/or part-time).* 2. I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required] 3. We are a corporation and its officers have exercised their right of exemption per c. 152, §1(4), and we have no employees. [No workers' comp. insurance required]** 4. We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.] *Any applicant that checks box #1 must also fill out the section below showing the staff the corporate officers have exempted themselves, but the corporation has other organization should check box #1.	Business Type (required): 5. Retail 6. Restaurant/Bar/Eating Establishment 7. Office and/or Sales (incl. real estate, auto, etc.) 8. Non-profit 9. Entertainment 10. Manufacturing 11. Health Care 12. Other ir workers' compensation policy information.	
I am an employer that is providing workers' compensation insure Insurance Company Name:	·	
Insurer's Address:	* <u>*</u>	
City/State/Zip:	· · · · · · · · · · · · · · · · · · ·	
Policy # or Self-ins. Lic. #Attach a copy of the workers' compensation policy declaration	Expiration Date: page (showing the policy number and expiration date).	
Failure to secure coverage as required under Section 25A of MGL fine up to \$1,500.00 and/or one-year imprisonment, as well as civi of up to \$250.00 a day against the violator. Be advised that a copy Investigations of the DIA for insurance coverage verification.	c. 152 can lead to the imposition of criminal penalties of a l penalties in the form of a STOP WORK ORDER and a fine of this statement may be forwarded to the Office of	
I do hereby certify, under the pains and penalties of perjury that	the information provided above is true and correct.	
Signature:	Date:	
Phone #:		
Official use only. Do not write in this area, to be completed by	y city or town official.	
City or Town:Per	Permit/License #	
Issuing Authority (circle one): 1. Board of Health 2. Building Department 3. City/Town C 6. Other	Herk 4. Licensing Board 5. Selectmen's Office	
Contact Person:	Phone #:	